contact between those managing patients and those managing the institution. They would also interact with financial advisers and institutional service managers at board level.

There are some difficulties in implementing a horizontally managed, team based approach. For example, governments, institutions, and professional organisations would need to modify existing regulations³ and redefine their relations. Individuals must learn to value each other's contributions and be prepared to work in small groups, with some of the conflict and intimacy that that implies.⁴ This, however, allows more opportunities for consultants to implement their many skills. A consultant's professional responsibilities include the management of patients, education of trainees and colleagues, and research. Administration is also a major commitment and includes personal time management, continuing education, quality control (audit), the development of policies and guidelines, committee work, and participation in professional and political organisations. Consultants are more able to fulfil these essential tasks by working in a team with a flexible skill mix.

In summary, consultants' professional role is enhanced by the opportunity for initiative, task sharing, and delegation within a team with a mix of skills. This can reduce role conflict,⁵ decrease stress, foster morale, and improve the quality of patients' care.

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- 1 Bailey J. Rethinking consultants. Time for change in traditional working practices? *BMJ* 1995;310:788-90. (25 March.)
- 2 Denton DK. *Horizontal management. Beyond total customer satisfaction*. New York: Lexington, 1991.
- 3 Who is a surgeon . . . [editorial]. *Lancet* 1995;345:663-5.
- 4 Sampson EE, Marthas M. *Group process for the health professions*. Albany, New York: Delmar, 1990.
- 5 Vachon MLS. Stress in oncologists. *Canadian Journal of Oncology* 1993;3:166-72.

Emotions aroused by being on call

Need for anonymity condemns profession

EDITOR,—The vivid thoughts about being on call described in a personal view will evoke deep feelings in many doctors.¹ I am approaching my mid-40s and face yet another weekend on call. I know that some of these thoughts will occur to me, although they are now familiar and rather worn.

The author of the personal view, reasonably, remains anonymous. Surely this must be the greatest condemnation of our profession—that so many of us will strongly identify with the emotions expressed but feel shame either to admit to them or to listen to a colleague who has them.

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- 1 Rites of passage of a medical career. *BMJ* 1995;310:1144. (29 April.)

Australian doctors extract financial penalty for extra hours

EDITOR,—I remember the resentment described by the young author writing about being on call¹; I call it bitterness now. I live in Australia but was educated in Britain. I have ruminated for years on the need for doctors' internment. I have never believed that it is a better education to walk the

dark corridors and prescribe paracetamol or, while disoriented, give an injection to the wrong patient. Long ago, however, I realised that there was no political will for change in Britain. In fact, as a group, doctors are particularly well managed by the health authorities in Britain.

Now I live in Australia, working 40 hours a week in accident and emergency, with one week of nights in every seven, for £10 an hour. Overtime is paid at double the normal rate or more. If more than 16 hours are worked in a day the fatigue pay is paid at double time the next day and fatigue leave can be, and is, taken. The cost of staffing inhibits excessive hours. I do not believe that the patients have suffered.

I am told that this system came about because of the threat of industrial action. I believe that it can and should be achieved in Britain: doctors' families and patients deserve it.

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- 1 Rites of passage of a medical career. *BMJ* 1995;310:1144. (29 April.)

BMA council's annual report

Is out of touch

EDITOR,—Sometimes I wonder how in touch the powers that represent us really are. A paragraph in this year's annual report of the BMA's council states: "That this Meeting urges the Editor of the *BMJ* to seek the inclusion of the following details in all job advertisements [for junior hospital staff] carried in the *BMJ*. . . (ii) number of UMTs payable."

We have been paid in additional duty hours since 1992.

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- 1 BMA. *Annual report of council 1994/95*. London: BMA, 1995:67.

BMA secretary's reply

EDITOR,—The BMA is aware that additional duty hours rather than units of medical time have been paid since 1992. The paragraph that Christopher L Sheen mentions refers to BMA policy made in 1990, before the advent of additional duty hours.

E M ARMSTRONG
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Postgraduate training in Italy

EDITOR,—We wish to add to the discussion about specialisation in Europe. In the past few years both the undergraduate and the postgraduate Italian medical curriculums have been reformed. Previously, no examinations had to be taken for entry to undergraduate courses and there were fairly relaxed entry examinations for the postgraduate curriculum; admissions have now been greatly restricted. In particular, postgraduate training changed dramatically with a reform in 1991 that was meant to bring Italian specialist training up to European standards. On average, the reform has reduced the yearly enrolment of postgraduate trainees by a factor of more than 10. Trainees are now requested to attend the wards for at least 38 hours a week, have to be on the on call rota, and in principle have the same clinical responsibility as the most junior permanent staff—that is, "as-

sistants," whose role is similar to that of the British senior house officers.

This reform is a great improvement, because previously postgraduate training consisted mainly of working from books and clinical practice was seen as optional. The new legislation and reforms, however, are only as good as the people who have to endorse them, and at present the reforms have not changed the attitude of trainers towards trainees. Thorough general teaching of practical skills and the subsequent acquisition of medical and surgical proficiency by all trainees are still a long way off in Italy. Most trainees do only menial jobs, such as clerking patients.

To act on this, in 1993 the Medical Association of European Union Specialists was set up. Members of the association comprise trainees enrolled since the 1991 reform. The association aims to be the Italian voice of specialists who have qualified in the European Union. It has over 4000 members and is working to improve training and trainees' conditions. Its second general meeting, on 11-12 March 1995 in Rimini, was attended by Mrs L Reilly, who is secretary of the Advisory Committee on Medical Training of the European Commission; she will present the issues raised to the commission. We are keen to be contacted by other European trainees to establish a permanent means of sharing experiences throughout the European Union so that better training is achieved both in Italy and in the rest of Europe. We believe that improved medical and specialist training is essential both to improve the standard of medical care and to reduce the costs of health care throughout the world.

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Hospitals pay value added tax on drugs

EDITOR,—I wonder how many doctors are unaware, as I was until recently, that hospital pharmacies pay value added tax on drugs and medicines. This comes out of the budgets of individual clinical directorates as part of their drugs bill, reducing the amount of money available for both inpatient and outpatient care. Community pharmacists can reclaim from Customs and Excise the value added tax that they have paid on drugs dispensed to patients presenting a prescription from their general practitioner, but hospital pharmacies cannot reclaim the tax.

This is not a new imposition, but I find it surprising and unacceptable in view of recent controversy about value added tax on domestic fuel, children's clothes, and books. Perhaps this anomaly should be considered further.

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Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.